ACTIVE PLUS PHYSICAL THERAPY

Consent to Treat & Privacy

Please read carefully and sign.

CONSENT TO EVALUATION AND TREATMENT

I voluntarily consent to physical and/or occupational therapy evaluation and treatment by the licensed clinicians of Active Plus Physical Therapy, PC. Treatment may include, but is not limited to, therapeutic exercise, manual therapy, neuromuscular re-education, functional training, gait and balance training, patient education and therapeutic modalities.

My therapist has explained, or will explain, the nature and purpose of my treatment, the expected benefits, possible risks (such as temporary soreness or fatigue) and alternatives. I understand that results are not guaranteed and that I may ask questions or decline any part of treatment at any time.

I agree to tell my therapist about any changes in my health, symptoms or medications, and to follow my home program to the best of my ability.

ACKNOWLEDGMENT OF PRIVACY PRACTICES

I acknowledge that I have been offered a copy of the Active Plus Physical Therapy, PC Notice of Privacy Practices, which describes how my protected health information may be used and disclosed and how I can access it.

I authorize Active Plus Physical Therapy, PC to use and disclose my health information for treatment, payment and health care operations, including communicating with my referring physician and insurance carrier(s).

I GIVE PERMISSION TO (CHECK ALL THAT APPLY)

- ☐ Leave detailed voicemail messages
- ☐ Send appointment reminders by text
- ☐ Send information by email

PERSON(S) WE MAY DISCUSS MY CARE WITH

RELATIONSHIP / PHONE

ATTENDANCE

I understand that consistent attendance is important to my recovery. I agree to give as much notice as possible if I need to cancel or reschedule an appointment.

SIGNATURE

PATIENT NAME (PRINT)

DATE OF BIRTH

PATIENT (OR GUARDIAN) SIGNATURE

DATE

IF SIGNED BY A REPRESENTATIVE: NAME

RELATIONSHIP / AUTHORITY